STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING _____ B. WING _____	R-C 09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Visit (PSR) to the Recertification and State Licensure Survey and for the PSR to the Investigation of Complaints IN00091583 and IN00092054 completed on 7/1/11. This visit was in conjunction with a PSR to the investigation of Complaint IN00094324 completed on 8/12/11. Complaints IN00091583 and IN00092054-Corrected Survey dates: September 6, 7, 2011 Facility number: 000153 Provider number: 155249 Aim number: 100266910 Survey team: Ann Armey, RN TC Sheryl Roth, RN Census bed type: SNF/NF: 145 Total: 145 Census payor type: Medicare: 8 Medicaid: 105 Other: 32 Total: 145 Sample: 14 Kindred Transitional Care and Rehabilitation-Fort Wayne was found to be in compliance with 42	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING _____ B. WING _____	R-C 09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the Recertification and State Licensure Survey and the PSR to the Investigation of Complaints IN00091583 and IN00092054. Quality review completed 9/8/11 Cathy Emswiller RN	{F 000}		